STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nevada

Attachment 4.19-A

The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

PAYMENT FOR INPATIENT HOSPITAL SERVICES
ASSURANCES AND RELATED INFORMATION

A. State Assurances and Findings. The State assures that it has made the following findings:

1. 447.253(b)(1)(i) - The State pays for inpatient hospital services through the use of rates that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable State and Federal laws, regulations, and quality and safety standards.

2. With respect to inpatient hospital services--

   a. 447.253(b)(1)(ii)(B) - The methods and standards used to determine payment rates take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs.

   b. 447.253(b)(1)(ii)(B) - The State elects in its State Plan to cover inappropriate level of care services (that is, services furnished to hospital inpatients who require a lower covered level of care such as skilled nursing services or intermediate care services) under conditions similar to those described in section 1861 (v)(1)(G) of the Act. The methods and standards used to determine payment rates specify that the payments for this type of care must be made at rates lower than those for inpatient hospital level of care services, reflecting the level of care actually received, in a manner consistent with section 1861(v)(1)(G) of the Act.

   c. 447.253(b)(1)(ii)(C) - The payment rates are adequate to assure that recipients have reasonable access, taking into account geographic location and reasonable travel time, to inpatient hospital services of adequate quality.

3. 447.253(b)(2) - The proposed rate will not exceed the upper payment limits as specified in 42 CFR 447.272:

   a. 447.272(a) - Aggregate payments made to hospitals for inpatient services when considered separately, will not exceed the amount that can reasonably be estimated would have been paid for under Medicare Payment principles.

   b. 447.272(b) - Aggregate payments to State-operated hospitals for inpatient services when considered separately will not exceed the amount that can reasonably be estimated would have been paid for under Medicare payment principles.

c. 447.272(c) - Aggregate disproportionate share hospital (DSH) payments do not exceed the DSH payment limits at 42 CFR 447.296 through 447.299.

d. OBRA 93 - DSH payments to ~~all~~ each hospital, including those owned or operated by the state or an instrumentality or unit of government within the state, beginning in SFY 1996, are limited to 100% of uncompensated costs. RC 7/31/96

B. State Assurances. The State makes the following additional assurances:

1. For hospitals --

a. 447.253(c) - In determining payment when there has been a sale or transfer of the assets of a hospital, the State's methods and standards provide that payment rates can reasonably be expected not to increase in the aggregate solely as a result of changes of ownership, more than payments would increase under Medicare under 42 CFR 413,130, 414.134, 413.153 and 413.157 insofar as these sections affect payment for depreciation, interest on capital indebtedness, return on equity (if applicable), acquisition costs for which payments were previously made to prior owners, and the recapture of depreciation.

2. 447.253(e) - The State provides for an appeals or exception procedure that allows individual providers an opportunity to submit additional evidence and receive prompt administrative review, with respect to such issues as the State determines appropriate, of payment rates.

3. 447.253(f) - The State requires the filing of uniform cost reports by each participating provider.

4. 447.253(g) - The State provides for periodic audits of the financial and statistical records of participating providers.

5. 447.253(h) The State has complied with the public notice requirements of 42 CFR 447.205. Notice published on June 30, 1995.

6. 447.253(i) - The State pays for inpatient hospital services using rates determined in accordance with the methods and standards specified in the approved state plan.

C. Related Information

1. a. 447.255(a) – Inpatient hospital:
Estimated average proposed payment rate as a result of this amendment: $1,067

Estimated payment rate in effect for the immediately preceding rate period: $1,067

Amount of change: 0 Percent of change: 0%.

b. 447.255(a) – DSH:
Estimated proposed payment per Medicaid day as a result of this amendment: $576.02

Estimated payment per Medicaid day for the immediately preceding rate period: $576.02

Amount of change: 0 Percent of change: 0

Nevada's aggregate DSH payment for this year and the immediately preceding year is $73,560,000. The DSH program this year is based on uncompensated costs for the majority of the hospitals, and not on Medicaid utilization. The amendment to the DSH methodology will have no effect on the payment per day.

2. 447.255(b) – The estimated short term and long term effect of the change in the estimated average rate on:

a. The availability of services on a statewide and geographic area basis: NONE

b. The type of care furnished: NONE

c. The extent of provider participation: NONE

d. The degree to which costs are covered in hospitals that serve a disproportionate number of low income patients with special needs.

The change in the disproportionate share program will restrict payment to those hospitals that specialize in providing mental health services to low income patients. Since payments to such specialized hospitals was minimal there is no indication that this change will limit provider participation, type of care provided or availability of services. In aggregate, none of the remaining hospitals will receive less and some will receive more as a result of the proposed change.

4. These rates are indexed to the fiscal year rate period using the Health Care Financing Administrator's hospital market basket index and rounded to the nearest $5.00.

III. NEONATAL RATE DEVELOPMENT

The pattern of utilization for neonatal services is very different from other categories. Consequently, a different method is used to adjust for the fact that most neonatal stays exceed 25 days. This is the opposite from the other categories where the length of stay is heavily weighted toward five days or less.

Neonatal costs for each hospital are divided by the number of neonatal patient days to determine a cost per day.

The rate is developed using the same steps as described in Section II, Parts C, D, and E.

IV. PSYCHIATRIC/SUBSTANCE ABUSE TREATMENT RATE DEVELOPMENT

Psychiatric/substance abuse treatment admissions can vary from short stays to several weeks. The length of stay does not significantly impact the cost per day. Therefore, a per diem rate is a more appropriate method to pay acute care hospitals providing this type of service.

Psychiatric/substance abuse treatment costs for each hospital are divided by the number of psychiatric/substance abuse treatment days to determine a cost per day. The cost of per day for general acute care hospitals is developed using the same steps described in Section II, Parts A through C. The Medicaid related costs of freestanding psychiatric hospitals are determined using the steps in Section II, Parts A and B, then dividing their Medicaid costs by their total Medicaid days to determine the cost per day. The calculated cost per day of each general acute care hospital and freestanding psychiatric hospital is arrayed from highest to lowest. The prospective per diem rate is then calculated at the 55th percentile and indexed in accordance with Section II, Part E of this plan.

These rates do not apply to facilities accredited as Residential Treatment Centers by the Joint Commission on Accreditation of Health Organizations (JCAHO).

V. DIEM RATE AND ADMINISTRATIVE DAY RATE DEVELOPMENT

A. Per diem rates are used to pay daily costs for long hospital stays beginning with the 26th day of hospitalization. The method used to develop a per diem rate consists of identifying the per diem cost for each hospital from the cost report and adding the average ancillary cost per day. The rate is developed using the same steps as described in Section II, Parts D and E.

B. Administrative Day Rate

For those patients who remain in an acute care hospital awaiting admittance to a long term care facility, an administrative day rate is used. Services so reimbursed are called "administrative days." Administrative days beyond three per admission require prior authorization from the Nevada Medicaid Office.

The administrative rate is calculated each year. It is based on the most recent statewide weighted average payment rate for skilled and intermediate levels of care plus a 100% factor. Under certain circumstances, up to an additional 300% is added for a patient with exceptional or abnormal needs; for example, patients in need of isolation, ventilation dependency, or total parenteral nutrition. The administrative rate, plus the maximum 300% factor, is lower than the hospital rate as described in Part II of this State Plan. These rates are rounded to the nearest $5.00.

VI. RESIDENTIAL TREATMENT CENTERS

Nevada Medicaid will only pay for stays in facilities accredited by the Joint Commission on Accreditation of Health Organizations (JCAHO) as Residential Treatment Centers (RTC's). All stays must be pre-approved by Nevada Peer Review. These services will be reimbursed at the lowest rate acceptable to both parties. In establishing the lowest rate acceptable to both parties, Nevada Medicaid reviews cost information filed by the RTC, amounts paid by other insurers, and nation literature on costs for RTCs. Each facility will have a negotiated rate established for each general level of service. If a placement is being proposed which is different from the general level of care offered by the facility, a rate will be negotiated after considering the average cost per day of the facility and the additional medical needs of the child. Rates will be reviewed not later than October 1 of each year based upon cost information received on or prior to July 1 of each year. The rate cannot exceed the reasonable and customary charges of the facility for similar services.

VII. HOSPITALS UNDER MEDICAID RETROSPECTIVE COST REIMBURSEMENT (SPECIALTY HOSPITALS)

A few Nevada hospitals are licensed to provide acute care for a single diagnostic category. To the extent these hospitals participate in Medicaid, they are reimbursed under Medicare's retrospective cost reimbursement (excluding psychiatric hospitals), as follows:

A. Inpatient hospital services which have been certified for payment at the acute level by a professional review organization, as specified in the contract between NevPRO and Nevada Medicaid, upon final settlement are reimbursed allowable costs under hospital-specific retrospective Medicare principles of reimbursement in accordance with 42 CFR Part 413.30 and 413.40, Subpart C, and further described in HCFA Publications 15-I and 15-II.

B. On an interim basis, each hospital is paid for certified acute care at the lower of 1) billed charges, or 2) the rate paid to general acute care hospitals for the same services.

Facilities accredited as Residential Treatment Centers by the Joint Commission on Accreditation of Health Organization (JCAHO) are not considered specialty or general acute hospitals. Residential Treatment Centers are paid in accordance with paragraph VI above.

VIII. HOSPITALS SERVING LOW-INCOME PATIENTS
DISPROPORTIONATE SHARE HOSPITALS

A. Subject to the provisions of paragraph 5, a hospital will qualify as disproportionate if it meets any of the conditions under paragraphs 1 through 4.

1. A hospital's Medicaid inpatient utilization rate is at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payment in the State.

OR

2. The hospitals low income utilization is at least 25%. Low income utilization is the sum (expressed as a percentage) of the fractions, calculated as follows:

   Total Medicaid patient revenues paid to the hospital, plus the amount of the cash subsidies for patient service received directly from State and local governments in the cost reporting period, divided by the total amount of revenues of the hospital for patient services (including the amount of such cash subsidies) in the same cost reporting period; and,

The total amount of the hospital's charges for inpatient hospital services attributable to charity care (care provided to individuals who have no source of payment, third-party or personal resources) in a cost reporting period, less the portion of any cash subsidies received directly from the state or local government, divided by the total amount of hospital charges for inpatient services in the hospital in the same period. The total inpatient hospital charges attributed to charity care shall not include contractual allowances and discounts (other than for indigent patients not eligible for Medicaid assistance under an approved Medicaid State plan), that is, reductions in charges given to other third party payors, such as HMOs, Medicare, or Blue Cross Blue Shield.

The period for which this data is selected from will be the same as that of the cost report used in the rate development process.

3. For public hospitals (i.e., hospitals owned or operated by a hospital district, county or other unit of local government), the hospital's Medicaid inpatient utilization rate is at least one percent.

OR

4. For counties which do not have a public hospital, the hospital in the county which provided the greatest number of Medicaid inpatient days in the previous year.

5. A hospital must:

a) have a Medicaid inpatient utilization rate not less than one percent.

b) have at least two (2) obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under a State Medicaid plan. In the case of a hospital located in a rural area (that is, an area outside of a Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget) the term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures. This does not apply to a hospital in which:

i) The inpatients are predominantly individuals under 18 years of age; or

ii) Does not offer non-emergency obstetric services as of December 21, 1987.

c) not be an institution for mental disease or other mental health facility.

B. Hospitals which qualify under paragraph 'A' will receive additional reimbursement as described below:

1. For hospitals that qualify solely under subparagraph '1' or '2' of paragraph 'A,' an additional $10 per inpatient day for all Medicaid days paid pursuant to this section of the State Plan.

2. For hospitals that qualify under subparagraph '4' of paragraph 'A.' an amount equal to their uncompensated costs for their previous fiscal year as defined in paragraph 'C.' not to exceed:

   a. $4,800,000 in a county whose population is more than 100,000 but less than 400,000.

   b. $2,000,000 in a county whose population is more than 35,000 but less than 100,000.

   c. $1,000,000 in a county whose population is less than 35,000.

3. For hospitals that qualify under subparagraph '3' of paragraph 'A,' an amount equal to their uncompensated costs for their previous fiscal year as defined in paragraph 'C,' subject to the limitation in subparagraph '4.'

4. The total disproportionate share to be paid out under this paragraph is limited to $74,000,000 per year. This is the amount to be paid during the Federal Fiscal Year starting October 1, 1999. If the amount that would otherwise be paid exceeds $74,000,000 all payments would be made to hospitals under subparagraph '1' and '2' as well as all payments for the first $500,000 of uncompensated costs for all hospitals under subparagraph '3'. Additional uncompensated costs for all hospitals under subparagraph '3' would then be aggregated and paid proportionally based on the remaining disproportionate share available.

C. Uncompensated costs are determined by the sum of the cost for providing services to inpatient and outpatient Medicaid and uninsured patients less Medicaid payments (excluding disproportionate share payments) and any patient paid or third party paid amounts. (Third party amounts exclude any payments made by a State or locality to a hospital for services provided to indigent patients.) An "uninsured patient" is defined as an individual for whom services received by the patient are not covered by insurance, whether this coverage is medical or liability based coverage. Patient paid and third party paid amounts are based on the historical collection experience of the hospital for uninsured accounts or actual collections in the fiscal year, whichever is greater. A system must be maintained by the hospitals to match revenues on Medicaid and uninsured patient accounts to the actual billed charges of the accounts in the same fiscal year. Costs for Medicaid and uninsured patients will be based upon the methodology used for a HCFA 2552 report. Revenue will be deducted from cost. The total costs on the report will be subject to an independent audit, which must be submitted within six months of the hospital's fiscal year end.